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PSYCHOLOGICAL INTERVIEWING WITH DEAF PERSONS

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B. Sachs

The topic for this PRWAD Psychology Section revolves around this question: What really goes on during the psychological interview when a deaf person goes for help? And what are the differences one may find in the *quality* of this interview when the deaf person seeks help from another deaf person and when he seeks help from a non-deaf person? Here, I refer especially to the initial interview since so much hinges upon this first meeting.

This topic came to my mind for two reasons. Firstly, I do not believe enough attention, if any, has been given to the initial interview where deaf persons seeking psychological, psychiatric or counseling help are concerned. Especially lacking is information concerning the qualitative differences in such interviews when it is the deaf or the non-deaf professional who is the helper. Secondly, a discussion on this very topic in a New York University graduate psychology class a few years ago engendered quite a bit of discord, hostility and defensiveness among many of the non-deaf students. Two students in this class were deaf; I was one of these two. Among the defenses exhibited was this statement: "Are they [the deaf students] trying to put us out of business?" The dispute was so remarkable that I hereby submit this topic bears further and closer scrutiny.

Finally, I wish to make clear that the desired attention is *not* on the deaf or non-deaf helper's relative effectiveness, one over the other, but rather, on the *differences in the quality of such interviews*. What are they? How can we identify them? What are the possible factors and dynamics

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involved that may account for such qualitative differences? I hope today's section meeting will mark the beginning of a more serious exploration of this interview-difference phenomenon.

Our first speaker is Dr. Allen Dittmann of the National Institute of Mental Health. He has for many years done research and written articles in the areas of human communication and psychotherapy.

A. Dittmann

I was asked to come today not because of any experience I have had with deaf people, but rather because of my experience with interviewing and research on interviewing, experience which might be applicable to work with any people. I have long been interested in what happens inside the interview, so to speak, in the interaction between the two participants. This interest began with research on the psychotherapeutic interview, so I have concentrated on variables related to an important feature of psychotherapy, the emotional interchange between the two people. In the early days of this area of research, many of us assumed that we could learn all we needed to know about a person by just listening to him long enough, since eventually he would say everything there was to say. But what is "long enough?" Few interviewers, even the most painstaking psychoanalytic ones, can possibly listen to everything that anyone could say. Furthermore, researchers cannot wait for long periods of time, especially if they want to study interaction within interviews. What they need is some way of getting at the immediate responses of the participants, responses to the topics that come up, to the questions or other interventions from the interviewer, or to the reactions the two people have to each other. And most people have a hard time saying in words what their immediate reactions are, partly because responses in the immediate present are difficult to look at, and partly because people are not always willing to give words to all the reactions that they do recognize.

In order to study immediate reactions, then, I turned to the technical aspects of language, hoping that the form of speech would supplement the content of speech in furthering my efforts. Later I added some other means of expression, and found that there are some relationships among all of them that are worthwhile studying in their own right. Let me list some of these means, or channels, now, and mention some of their characteristics. Later I shall come back to some applications of some findings in this area to interviewing — and that includes interviewing deaf people.

Language is obviously a very rich medium for any sort of communication, whether by speech or by signing, in spite of the problems I have mentioned above. Needless to say, its richness applies to emotional communication as well: one can express many things about one's feelings in words. Another means, in many cases more immediate than language, is facial expression. In their purest form, these expressions are probably rather

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limited in number, and refer to specific emotional states that are universal to all mankind. In addition, there are many possible blends of facial expressions which we all learn to read because they appear to be built into all of us.

Language and facial expression share an important characteristic: they can refer to very specific feelings and emotional states, like anger, sadness, happiness, surprise, and the like. We don't often think of any other way of expressing feelings, since we think in terms of words like these when we think of emotions. But there are a number of other channels, tone of voice, for example, and some bodily expressions, which give us more general cues about feeling states, such as tension or relaxation. There are a number of these: fidgetiness, visible tightness of muscles, passing facial cues of fatigue like the "drawn look," which tell us of tension or discomfort. Postural changes, as a person leans toward a person he likes or away from one he dislikes, give other cues — even where he placed his chair in the room can be very telling. Then within language itself there are a number of these nonspecific tension-type cues we would do well to learn more about: one can notice repetitive themes in a person's discourse that tell us about the things he is preoccupied with; for some people there are types of words that indicate something general about what he is feeling: the ever-present "sort of," or "to a certain extent," or "almost," or "it seems" — all ways of qualifying what he is about to say. So there are really quite a number of channels of communication that can contain messages of the feeling or emotional state that the person is experiencing right now. A few, like language and facial expression, are definite and specific, but most are general and serve only as cues from which we infer feelings and moods.

Now let me talk briefly about some applications I see from these various means of expression to interviewing. One of them, voice quality, of course, is absent if one is dealing with a deaf person, but I have no doubt that there is a corresponding one applicable to signing. An interviewer would have to know a good deal about the special language of signs to read feelings from the way a person hesitates, makes movements that seem tense, or whatever. I want to say a bit more now about the ways an interviewee might conceal or try to conceal how he really feels. By "conceal" I don't mean only that he is hiding his real feelings from the interviewer, but that he might also be trying to conceal his immediate reactions from himself as well. How a person tries to present himself is very important in understanding what he is going through and what he is upset about. Research by Paul Ekman of the University of California on just this process among hearing people shows that those channels of expression which are the most specific and which we all feel intuitively are the most expressive are the ones that people use to try to conceal their feelings. These are facial expression, and language as we saw before. Language was not studied directly in Ekman's research, but it is obviously also used in hiding feelings — we all choose our words carefully in some situations. I would expect that where a person has learned another language like signing, he would try to conceal his feelings through that

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means, too. These channels capable of specific, definite messages are the easiest to think about and to try to control. The other channels, the ones through which we see tension-state types of expressions like in musculature, fidgetiness, or whatever — these are not as subject to conscious control, and one can see emotions leaking through in these expressions. They are not controlled because it doesn't occur to the person to try to control them. He thinks of expression only in terms of those channels everyone knows are the most expressive.

Whether a person is hiding his feelings is not the only important thing an interviewer is looking for, nor is it the only thing that comparison of these different channels of expression can tell us about. I hope, however, that the research results I just talked about can be a spur to your interest in thinking about all sorts of communication.

B. Sachs

Our next speaker is Allen Sussman who is now with the Deafness Research and Training Center at New York University. He has had several years of experience in psychotherapy with the deaf at Maimonides Medical Center, where he will soon become Coordinator of their Counseling and Mental Health Services for the Deaf.

A. Sussman

Falling in line with Dr. Dittmann's presentation, I will relate my own experiences in psychological counseling and psychotherapy with deaf children and adults. Although the implications are broad, many principles and issues within the general field of psychotherapy are applicable to the deaf.

A cardinal rule, as all psychotherapists know, is to communicate with the client or patient in a mode that he prefers or is most comfortable with. All else being equal, the variable of comfort in communication can make or break the relationship between client and therapist. Comfort means more than just being comfortable with a communication mode, more than the facilitation of understanding and empathy. It conveys the accepting attitude of the therapist who shows respect for his client's preferences, and consideration for whatever language problems he may have. At our Community Mental Health Center in New York City, provisions are made for its polyglot population. For instance, we have a Spanish-speaking therapist for Hispanic people and a Hebrew-speaking therapist for Hasidic Jewish immigrants.

It goes without saying that a vast majority of deaf people prefer — and are more comfortable with — the sign language. The necessary condition of

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comfort in communication will not be provided if the deaf client is confronted with a therapist unable to communicate in the sign language — expressively as well as receptively. If a hearing therapist fluent with the sign language accedes to his deaf client's wish to use the sign language, the therapist is also accepting his client as a person, for he is accepting his client's language which is a part of him.

This concept of comfort in communication is applicable to *all* deaf people, including those who disdain the use of the sign language. I have made mistakes in the past, and I have learned never to take any deaf person for granted. For example, I once introduced myself to a prospective client in the sign language. He became angry and said that he was an "oralist." I got off on the wrong foot, to be sure. Nonetheless, he remained my client for seven months, and we used oral communication, a communication mode he is comfortable with. I have also gone over parents' heads in working with deaf children. Because those children preferred to use the sign language and asked me to use it with them despite their parents' wishes to the contrary. After all, those children are in therapy, not their parents. The problem becomes complicated in the family therapy situation when there is a conflict between communication preferences of the child and parents.

To accommodate all principals, I use the simultaneous method (oral and sign language), but *always* within the conceptual and perceptual level of the child. It is easier for the parents to come down to the child's level than for him to go up to theirs. I have found this approach to work very well with parents who are either opposed to the sign language or are unable to use it, or both. This often proved to be a learning experience for the parents in that they gain insights regarding their child's conceptual level of communication. And the fact that the child is better able to express his feelings via a method of preferred communication is rarely lost on parents. More often than not, after a few sessions, the parents would ask where they could obtain sign language instruction. Through family therapy, they have learned the meaning of comfort in communication.

Although I am myself deaf, being able to communicate also with the low-verbal deaf people, I still have had to learn the highly unconventional, esoteric, idiographic and pantomimic sign language and gesticulations of two deaf population groups: black deaf and Hispanic deaf people, especially those from the ghetto and other deprived areas in New York City. Since I do considerable work with them, I wanted them to have the benefit of communicative comfort and, thus, acceptance. [Here, Mr. Sussman gave some graphic demonstrations of such communication with these two ethnic groups.]

While I am cognizant of a strong movement in this country to "upgrade" our formal sign language, it is my strong belief that manual and bodily communication *as used* by such racially, ethnically and culturally deprived low-verbal deaf persons should be made part and parcel of sign language training programs for professional people working with the deaf.

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Such knowledge will serve as invaluable counseling and psychological tools in working with such deaf individuals – and they are now legion.

What I have mentioned about communication comfort is only a reflection of the essential qualities in a counseling or psychotherapy relationship: understanding, acceptance and positive regard. It is beyond the scope of this panel to discuss their deeper implications in such relationships, but the attitude is that of accepting the client for what he is, willingness to allow individuals to differ from one another in all sorts of ways and, finally, a realization that the ongoing experience of each person is a complex pattern of striving, thinking and feeling. The client is being accepted for what he is, regardless of how he may disparage himself or think he has done something bad. And deaf people do appreciate those qualities in his relationship with the therapist or counselor. He has someone who will not criticize him. Most importantly, he knows that when he communicates with his counselor, he will understand and be understood.

B. Sachs

For the past twelve years I have been fascinated with the possibilities of psychotherapeutic communication with deaf individuals. My two years with the Psychiatric Institute in New York City and the four years I have now had with St. Elizabeths Hospital here in Washington, D.C. have afforded me ample opportunity to observe and experience psychotherapeutic interviews with deaf individuals. I shortly noticed that there were differences between those interviews in which the therapist is deaf and those in which he is hearing. But, until now, I couldn't put my finger on what these differences were or how they could be identified. I felt only that they probably did not have that much to do with whether or not the hearing therapist knew sign language; in fact, I observed that some of them were quite fluent in it expressively as well as receptively, yet, these observed differences remained. That these still-unnamed differences do in fact exist have not, as far as I know, been experimentally substantiated. However, I have shared my observations with a number of other deaf and non-deaf therapists and counselors and discovered that their observations agreed very much with mine. Interestingly, while some of the hearing therapists were quite objective in describing their observations of these differences, many were defensive. It was as if these so-called differences implied their professional inadequacy or incompetency. This is unfortunate, but I believe that present and later experimental studies will point out that their fears, on this basis at least, are unfounded.

Dr. Dittmann and Mr. Sussman have brought up a number of variables worth investigating that may account for the qualitative differences in interviews where the interviewer is deaf or non-deaf. I would like to submit that, among these and other variables, one of the most important may be

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identification. If a deaf patient or client identifies with his therapist or counselor, then the quality of his communication with him would differ from that in an interview where this identification does not occur.

In a pilot study I did two years ago, using Gallaudet College students as subjects and deaf and hearing mental health workers as interviewers, I set out to find differences in two dependent variables that could be measured: superficiality and resistiveness. [Resistiveness is attributed to statements in which communication about one's problems are minimized, denied, qualified, justified or blocked.] The results indicated that the deaf individual exhibited more resistiveness but less superficiality in his communication with his deaf interviewer, less resistiveness but more superficiality with his non-deaf interviewer.

This is but a beginning investigation of psychotherapeutic communication with deaf individuals. Certainly, many other variables have not been mentioned or identified. There is no doubt that this is an extremely fruitful area for exploration and discovery.

And, now, Dr. Dittmann, would you like to give a summary?

A. Dittmann

We have talked about many things, and a simple summary is difficult. We have heard this afternoon experiences from two vastly different points of view — the researcher who has had little experience with dealing with deaf people in interviews, trying to forecast from a theoretical standpoint what sources of difficulties there might be and what modes of communication might be particularly used by deaf people. And, also, we have heard from two people who have had a great deal of experience working with deaf people about the sorts of things that actually do happen. I'm interested myself in the problem of whom a deaf patient would work best with: another deaf person as the helping person, or someone who is not deaf? As we were having coffee before this, I expressed a hunch that if there were a long-term relationship between a deaf patient and a hearing therapist, it would probably be possible for the difficulties in communication to be ironed out so that eventually all the important problems would be covered. In a short relationship, on the other hand, and time-limited therapy is necessary in many places, it would be difficult to get over that first hurdle of communication. I'm sure, too, that the non-deaf therapist would have more difficulty with his first deaf patient, because he would have to learn about the problems that deaf people have in communicating with hearing people. He could, as he gained more experience, come to recognize some of the problems that Mr. Sussman has pointed out — they would apply no matter who the therapist was. The deaf person has had a life of isolation, and he needs someone outside to communicate with in order for him to feel better.

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And these problems the hearing therapist would have to learn about so he could better understand what his deaf patients are going through.

B. Sachs

Thank you, Dr. Dittmann. And, now, we have about fifteen minutes for questions.

Question:

Mr. Sussman, you say that you can't criticize a patient for the wrong feelings. How has that met with, let's say, a therapeutic approach, whereby a patient will come to you with an emotional disorder and you have to involve yourself in a way that's really critical but which can change the approach of the patient? Here's your chance to defend yourself.

A. Sussman

First of all, there is no "wrong feeling," that is, in a psychotherapy sense. Of prime concern is the way he feels, why he feels that way, and how he expresses his feelings. Second, an important condition in a psychotherapy relationship is the absence of threat. And criticism is a potent form of threat. Threat to the self and the self-concept seems to be one of the chief causes for personality disturbances or poor mental health. And for the therapist to be critical of the patient not only makes him more defensive but also can serve to be antitherapeutic. Changes in attitudes and behavior and "behavior for the better" occur only under conditions of absence of serious threat to the self and self-concept. Respect for the patient, interest in and acceptance of him as a person, absence of evaluative attitudes, and understanding him by seeing his point of view — all contribute to an atmosphere devoid of threat. So, as you can see, as a therapist, I cannot and will not involve myself in any way that would be a threat to the patient.

Question:

I'd like to ask Mr. Sussman and Mrs. Sachs, primarily. Neither of you mentioned the possibility of using group therapy for the deaf. I'm presently in graduate school at the University of Maryland with an internship at Gallaudet and deafness is new to me. And I've often wondered what the effects of having five deaf clients at one time interacting together would have. I've had some experience with groups of hearing but never deaf and

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I'm wondering if you have ever tried it and if there is any research on group therapy available and especially with the deaf?

B. Sachs

There has not been very much research on group therapy with the deaf. Interest in this is fairly recent and it is increasing. I can refer you to four publications on this that come to my mind right now. There is Dr. Luther Robinson's article in a 1965 issue of *Mental Hospitals*. Also in this issue is Dr. John Rainer's article. Then there is New York University's Deafness Research and Training Center monograph, *The Use of Group Techniques with Deaf Persons*. Finally, there is Dr. Larry Stewart's doctoral dissertation done at the University of Arizona in 1969.

Using group therapy with deaf individuals is beyond any doubt definitely possible. My experience and the experiences of others bear this out.

Speaking out of my own experience in this — I have worked with both in-patient and out-patient groups — the first thing I think is very important to point out is that each of my deaf patients is a member of the deaf community. They comprise a cultural minority group, a very small group indeed. Almost everybody knows everybody else. So, when one comes for help and goes to a group, one of the first reactions is that of fear and mistrust. It is as if he hopes he doesn't find anyone he knows. Usually, however, he does. In my group therapy work with deaf patients at St. Elizabeths Hospital, this is — as I expected — the first thing they bring up. They are encouraged to explore their feelings about discovering someone else in the group they know. Eventually, they learn to trust each other. Admittedly, this takes time. Sooner or later, they find that the fact that they might know each other from a previous time or place is *not* the problem.

A. Sussman

Although this is only tangential to group therapy, I'd like to share with you a little bit of my experience in group work with deaf adolescents last summer at the Junior NAD Youth Leadership Camp. I called it group dynamics, but it was along the lines of sensitivity training or T-Group or, more specifically, human relations. The goals were to help each teenager to develop a better understanding of themselves, of others, and to gain some insight into their relationship with other people. I worked with three different large groups, each meeting three times a week for a month.

The group approach was an entirely new experience for them and I think they enjoyed it. I started with the "theme-centered" approach, using a "safe" topic. In later sessions, when the participants began to feel more

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comfortable with one another, we moved on to more sensitive areas that involved considerable emotional feelings. As we progressed, they were permitted to talk about whatever they wanted. During the last two weeks the deaf teenagers talked quite openly about their feelings and problems in connection with their deafness, families, schools, etc. The sessions were especially beneficial to those few who had difficulty in adjusting to the camp situation. The tone was of sharing of feelings and problem-solving. Interestingly, with each session I found myself less and less active as group leader. Group work with deaf adolescents is potentially a fruitful area of endeavor.

Question:

In my work with the deaf, I personally have always enjoyed going to deaf clubs and other places where deaf people from the deaf community congregate. Although I am a deaf professional person myself, I note a trend among "well-placed" deaf professional people who make it a practice not to socialize with the rank-and-filers of the deaf community. The attitude is that of "I shall not be associated with the deaf man in the street — in his habitat, in his club, etc." That bothers me personally. What is your feeling about this, Mr. Sussman?

A. Sussman

Each to his own. This kind of attitude does not exactly endear deaf professional persons to the deaf community. Some have their own reasons — professional as well as personal. And I think you are especially referring to those who are in the helping professions and those who have deaf clients. Speaking for myself, I would go to civic and social functions in the deaf community. Invariably, I would meet many of my clients and ex-clients. This is unavoidable. But I would not stay away because of this. Why should I? I enjoy those functions and meeting deaf people. If deaf individuals accost me with their problems, I tell them that I will be happy to see them during office hours and I give them my card.

I think it is vitally important for the deaf professional person to keep in touch with the deaf community. There is much going on within it that will be useful to him in his work with deaf people and especially to the agency he represents. And most important, his occasional appearance admits the rank-and-filers shows that he is no snob, all of which will ultimately redound to his professional standing within the deaf community itself.

There is, however, a particular activity I would avoid — politics and running for office on the club and local levels. Deaf people are understanding once you take the trouble to explain to them why you had to respectfully

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decline nominations for office. I attend meetings, cast my secret vote, serve on committees, or serve in any capacity that is not likely to involve interpersonal friction. I repeat, I am speaking for myself. Others may think differently.

B. Sachs

Speaking for myself, I'll just say I feel the same way Mr. Sussman does. He has taken the words out of my mouth. I'll add one more reason why I advocate socialization with the rank-and-filers: this is an excellent method of letting them know that there *are* deaf professional persons around and that they are available to serve them.

Question:

Have you had any experience in group therapy with low-verbal deaf people and what have been your experiences in that?

A. Sussman

Group techniques I am using with low-verbal deaf people are based on principles of psychodrama. Since such deaf individuals generally do not have the "verbal" tools with which to express their thoughts and feelings to the fullest, I have encouraged them to *act* out their thoughts and feelings — in addition to what they are able to express via the sign language. I have found that role-playing and reverse role-playing are quite effective. The group therapist, however, has to be more active — physically as well as mentally. He must move around, in keeping with the "flow" of interpersonal transactions and simultaneously analyze feelings, responses and behavior. Yes, it is hard work, but effective.

A great group therapy tool is the videotape, and I believe that its potential in this respect has only been barely tapped. For instance, instant replays enable the group participant to see himself as he appears to others and how they react to him.

Question:

How many professional counselors do you know of that are qualified to work with the deaf? Where are they? How do we go about getting deaf people to them?

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A. Sussman

It depends on what type of counseling or psychological assistance the individual needs and the availability of *qualified* professionals to meet them. It might be helpful to break those needs down into two areas: cognitive and conative. Cognitive counseling in the main refers to information giving, advice, re-education, helping the individual develop existing resources within himself to meet his problems, most of which are on the intellectual level, requiring a minimum of emotional involvement. The latter inheres considerable emotional involvement, dealing with attitudes, conflicts, defenses, and attempts to change behavior and self-image. And that is another kettle of fish. With respect to conative type of work, there are a deplorably few scattered across the country qualified to do it. Such individuals either have had training on the doctoral level or special training in psychotherapy, or both. In the wake of these unmet needs there are bound to be *unqualified* people who will be tampering with the psyches of deaf individuals. It is happening at this moment. In the general field of psychotherapy it has its share of quacks, charlatans posing as "psychological professionals."

B. Sachs

To answer this question more specifically, the hearing professionals qualified to serve the mental health needs of the deaf are few and far between. But this past decade has seen an increase in their numbers; hopefully, future decades will likewise see more. Those presently in this field can be found at these following places: St. Elizabeths Hospital in Washington, D.C.; Rockland State Hospital in Orangeburg, New York; Michael Reese Hospital in Chicago, Illinois; and the Langley Porter Neuropsychiatric Institute in San Francisco, California. A recently established program is now in operation at the Maimonides Medical Center in Brooklyn, New York.

As far as I now know, there are only two deaf professionals in this country who are qualified to do psychotherapy. One works in a mental institution and the other, in a Community Mental Health Center. There are, of course, a greater number of deaf counselors, the majority of whom work in rehabilitation and educational settings. Hopefully again, future decades will see an increase in the numbers of deaf professionals serving the mental health needs of the deaf community.

Question:

On what basis do you choose the people who are in a group, who are going to have group therapy? Do you base it on similar problems, or ages?

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How do you get a group together? Say, you have several hundred deaf people: how do you decide which people to put together in a group?

A. Sussman

With deaf adults you do not have as much latitude as with hearing people. No, I do not have several hundred people to choose from. I am limited to 50 or so on our rolls at the Mental Health Center – *and all of them do not*, most of them do not require group therapy. Although I would prefer to have participants in a group “strangers” to each other, this, in reality, is virtually impossible. Perforce, I would ask each one of them individually if they would be amenable to sharing experiences with others whom they might consider acquaintances. The group, then, would be set up of individuals who have agreed to become members of the group. It has been my experience that, after all the preliminaries and initial resistances, each participant fell into earnestly. Relatively speaking, I think I have more elbow room in the selection of patients for group therapy in New York City. It may be much more difficult in smaller deaf communities.

B. Sachs

Each patient I see at St. Elizabeths Hospital has individual sessions with me first. On the basis of their psychopathologies, I would try to put them in homogeneous groups. Now, with members of the deaf community, this is not always possible – as Mr. Sussman has just pointed out. My group therapy patients are deaf: in this respect, the group is homogeneous. But in most other respects, they are vastly heterogeneous as to diagnostic impressions, coping mechanisms, educational attainments, and so forth. Nevertheless, the groups have progressed extremely well.

Question:

We have very little evidence that talking therapy works in the hearing community. What special reason do you think it would work in the deaf community?

A. Dittmann

To begin with, that's not true. We do have a good deal of evidence about the efficacy of psychotherapy. There have been a number of quite recent literature reviews which I can refer you to later.

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Question:

Because there are so few therapists, interpreters sign themselves as a triangle in a one-to-one therapy situation. Do you have any information or meetings that the interpreter may become aware of and can give to the hearing-oriented family?

B. Sachs

It has been my experience during the early years of my career to be the "third party" in interpreting for both doctor and patient. I found that, although probably "better than nothing," this arrangement is highly dissatisfying, too time-consuming and extremely inhibitive in its influence on the therapeutic process.

A. Sussman

I would not rule out the use of interpreters. Of course, a dyadic relationship in psychotherapy is ideal, but with deaf people this ideal often cannot be adhered to. It will be a happy day when we have a bevy of psychotherapists who are able to communicate, expressively and receptively, with all kinds of deaf children and adults. We must, however, deal with today's exigencies. The fact is that we do not have sufficient such therapists. It is better to use an interpreter when there cannot be a meaningful communication between therapist and deaf patient, than not to have treatment at all. I state this qualifiedly in that the interpreter, in addition to sign language skills, must be conversant with general principles of psychotherapy and code of ethics surrounding such relationships.

Question:

Is it required of counselors and therapists to obtain psychotherapy themselves?

A. Dittmann

I have never believed that there is a single answer to that question. There are people, counselors, who could benefit from psychotherapy and others who don't really necessarily require it. I have never felt that people who were counselors, who have had psychotherapy, have had any corner on the market of helpfulness and so maybe they could benefit and maybe they

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don't need it. I don't have any specific feeling or knowledge about counseling and rehabilitation or counseling with deaf people.

A. Sussman

In general, I agree with Dr. Dittmann. However, I think that there are special considerations concerning the *deaf* counselor, especially when he is doing some in-depth work with his deaf client. He should at least be conversant with the counter-transference phenomenon in his relationship with a deaf client. There is always the danger that he may inadvertently associate his own problems with those of his client, reacting to his own feelings rather than the client's. The concept of counter-transference and methods of controlling it is equally applicable to hearing counselors who have deaf family members.

Question:

What about "paranoid," that most over-worked word in the English language where the deaf are concerned?

B. Sachs

Yes, in my opinion, many of us deaf people are paranoid, but usually with good reason. So, we have to be careful to distinguish between paranoid in the psychotic sense and paranoid in the "justified" sense. I would like to see a better word than "paranoid," however.

A. Sussman

I would not characterize deaf people as being paranoid or even as having paranoid tendencies. Paranoia is a psychotic condition and is based on the delusional. I would say that some deaf people are suspicious and that for the most part their suspicions are based on reality. It is a fact that deaf people are being discriminated against; they are often exploited and taken advantage of; they are often ostracized, ridiculed and depicted in many derogatory senses by society. Many deaf people carry memories of suffering at the hands of hearing children during their childhood. They have been maligned and hurt by hearing people and it is only natural for them to guard themselves against further pain. Moreover, psychiatric studies have pointed out that there is no evidence of a preponderance of paranoid symptoms in deaf adults. I think that it is unfortunate that their suspiciousness has been interpreted as paranoia.

PSYCHOLOGICAL INTERVIEWING WITH DEAF PERSONS

An analogy can be drawn from a recent study on the “suspiciousness” of black people. They, too, have been characterized as paranoid towards white people. It was advanced that it is normal for black people to be suspicious, considering the way white people treat them. It was also added that it is abnormal for a black man not to be suspicious, otherwise he would not be able to cope with a racist society. The study concluded that a better understanding of black people would ensue if we do not always adhere to a white man’s frame of reference. Likewise, a better understanding of deaf people may come about if we do not always adhere to a hearing man’s frame of reference.